Confidential New Client Health History

Please type or print clearly

-**Please email completed form to jenas_mailbox@yahoo.com**-

Name: _____

Address: _____

Email address: _____ How often do you check email? _____

Telephone – Work: _____ Home: _____ Cell: _____

Age: _____ Height: _____ Date of Birth: _____ Place of Birth: _____

Current weight: _____ Weight six months ago: _____ One year ago: _____

Would you like your weight to be different? _____ If so, what? _____

Relationships status: _____ Children? _____

Relationship satisfaction scale (10 high, 1 low) _____

Occupation: _____ Hours of work per week: _____

Job satisfaction scale (10 hi, 1 lo) _____ Job stress scale (10 hi, 1 lo) _____

How is your attitude about life? (10 high, 1 low) _____ Do you feel/get angry? (10 Often, 1 rarely)_____

Do you sleep well? _____ Do you wake up at night? _____ What times? _____

To urinate? _____ What time do you generally get up in the morning? _____

Constipation/Diarrhea? _____ Explain: _____

What blood type are you? _____ What is your ancestry? _____

Have you been told you have high cholesterol? If so do you know your numbers? _____

How much water do you drink per day? _____

Women: Are your periods regular? _____ How many days is your flow? _____ How frequent? _____

Painful or symptomatic? _____ Please explain: _____

Do you take any supplements or medications? If so, which? _____

_____

Are there any healers, helpers or therapies with which you are involved? Please list: _____

_____

What role does exercise play in your life? _____

Do you drink coffee, smoke cigarettes, or have any major addictions? _____

Jena S. Griffith, RDN, IHC

What percentage of your food is home cooked? ..... Where do you get the rest from? .....

Serious illness/ hospitalizations/ injuries? .....

_____

Have you taken antibiotics
for long periods of time? .....

Recent Vaccinations .....

What is your chief concern? .....

Other concerns? .....

What have you done in the past to address these concerns. _____

_____

What is motivating you to take action now? _____

_____

How is the health of your mother? .....

How is the health of your father? .....

Any known food allergies or
sensitivities? .....

Confidential Health History - Part Two

Please write or print clearly

What foods did you eat often as a child?

Breakfast	Lunch	Dinner	Snacks	Liquids

What about one year ago?

Breakfast	Lunch	Dinner	Snacks	Liquids

What's your food like these days?

Breakfast	Lunch	Dinner	Snacks	Liquids

Please use this space to include any other relevant information (for example: current stress levels, recent traumas):